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AUTHOR Wasik, Barbara Hanna; Lam, Wendy K. K.; Kane, Heather

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ABSTRACT

This report summarizes and analyzes information on nine 1993 community integrated service system (CISS) projects to promote physical, psychological, and social well-being for all pregnant women and children, adolescents, and their families; provide individualized attention to their special health care needs; and link health care and services with other services and programs including early intervention, educational, vocational, and mental health services. These projects emphasize the creation of service systems incorporating 10 principles of care: (1) family-centered; (2) community-based; (3) coordinated; (4) culturally-competent; (5) comprehensive; (6) collaborative; (7) universal; (8) accessible; (9) developmentally appropriate; and (10) accountable. Information is based on a review of project proposals, the project continuation requests, and first year reports. The nine projects are located in Connecticut, Florida, Minnesota, Mississippi, Nebraska, Oregon, Wisconsin, and Washington, and serve primarily low-income, minority families. The major finding is that the principles of care called for by the 1993 CISS guidance continue to be identified as important elements in the design and implementation of the projects. However, there is considerable variability among the projects in their reports of how they are integrating these principles into practice. Recommendations are that project directors be provided with opportunities for more interaction with each other; more assistance with training, technical assistance, supervision, and evaluation; and that they receive additional information in implementing the principles of care. (Contains 21 references.) (Author/KB)

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Barbara Hanna Wasik

Wendy K. K. Lam

Heather Kane

The School of Education

The University of North Carolina at Chapel Hill
CB3500, UNC-Chapel Hill
Chapel Hill, North Carolina 27599-3500
Phone (919) 966-7000 FAX (919) 962-1533

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Barbara Hanna Wasik

Wendy K. K. Lam

Heather Kane

University of North Carolina at Chapel Hill

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Table of Contents

Abstract 1

Executive Summary 3

Report 11

I. Introduction 11

II. Methods 17

III. Results 19

IV. Summary 38

V. Recommendations 41

VI. References 45

VI. Appendixes

Appendix A Initial Proposal Form
Appendix B Annual Report Summary Form
Appendix C Summary Tables
Appendix D Ten Principles of Care Outlined by the Bureau of Maternal and Child Health's Community Integrated Service System Guidance (Table)
Appendix E Principles of Human Service Care Rating Scale

The 1993 Community Integrated Service System Projects:

A Report of the Initial Plans and Implementation Efforts

Abstract

In 1993, the Maternal and Child Health Bureau (MCHB) funded nine community integrated service system (CISS) projects to address concerns with infant mortality and to improve the health of all women and children in the United States. These projects emphasized the creation of service systems that incorporated ten specific principles of care: family-centered, community-based, coordinated, culturally-competent, comprehensive, collaborative, universal, accessible, developmentally appropriate, and accountable. The emphasis on these principles reflected a shift in focus from the first funding cycle in 1992, which emphasized the utilization of six specific service strategies, including home visiting and one-stop shopping, to emphasizing the development of a system of services in the community where the projects were located.

The purpose of the 1993 CISS initiatives was stated as follows: "In order to respond to the need for coordinated services, MCHB has established the development of community-based service systems as a top priority. The systems are intended to: promote physical, psychological, and social well being for all pregnant women and children, adolescents and their families; provide individualized attention to their special health care needs; and link health care and services with other services and programs including but not limited to early intervention, educational, vocational, and mental health services" (p. 1).

The purpose of this report is to summarize and analyze information on the nine 1993 projects using information obtained from a review of the project proposals, the

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project continuation requests, and first-year reports. The nine projects are located in eight states (Connecticut, Florida, Minnesota, Mississippi, Nebraska (2), Oregon, Wisconsin, and Washington) and serve primarily low-income, minority families. The reports were analyzed between May and September of 1994 through a contract to the University of North Carolina. Summary information was presented at the Community Integrated Service System and Home Visiting Grantees Meeting held in Bethesda, Maryland, July 10-13, 1994.

This report provides a more detailed presentation and analysis of data than was presented at the meeting in Bethesda, including information on background variables, program variables (procedures, strategies, and principles), outcome measures, and evaluation procedures, as well as specific recommendations. A major finding of this report is that the principles of care called for by the 1993 CISS guidance are being identified as important elements in the design and implementation of the 1993 CISS projects. There is, however, considerable variability among the projects in their reports of how they are integrating these principles into practice. Based on the review of these projects and on feedback obtained at the Community Integrated Service System and Home Visiting meeting, it is recommended that project directors be provided with opportunities for more interaction with each other and more assistance with training, technical assistance, supervision, and evaluation. It is also recommended that they receive additional information in implementing the principles of care emphasized in this initiative.

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The 1993 Community Integrated Service System Projects:

A Report of the Initial Plans and Implementation Efforts

EXECUTIVE SUMMARY

In 1993, MCHB funded nine new projects through the CISS initiative. The Bureau requested an evaluation of the initial implementation efforts of these nine projects in order to obtain a more comprehensive understanding of the projects than could be obtained by reviewing each one individually, and to inform policy decisions concerning community integrated service systems. The Bureau had previously funded an initial evaluation of the 32 projects that were begun in 1992 to provide summary information and to inform policy decisions involving the Bureau's initiative to promote community integrated service systems (Roberts & Wasik, 1994).

The specific objectives of this review are the following: (a) to provide a synthesis and analysis of information on the nine 1993 CISS projects, (b) to present this information at the July 1994 Community Integrated Service Systems and Home Visiting Grantees Meeting, and (c) to make recommendations to the Maternal and Child Health Bureau regarding the 1993 CISS projects in relation to community integrated service systems.

The conceptual model used in this analysis is responsive to shifts in philosophy concerning services for children and their families (Wasik, Bryant, & Lyons, 1990). These shifts include a greater emphasis on working with the entire family rather than focusing only on the child. The shifts also include a trend toward services that are flexible and responsive to child and family needs rather than restrictive and standardized in nature.

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The role of the service provider also has shifted from that of expert decision maker to collaborator and facilitator (Wasik et al., 1990).

Methods

The nine CISS projects funded in 1993 were reviewed by a research team at the University of North Carolina at Chapel Hill under the direction of Barbara H. Wasik, Ph.D. Three major activities were undertaken: (a) review of the initial proposals, (b) review of the annual reports and continuation requests, and (c) presentation of summary information at the Community Integrated Service Systems and Home Visiting Conference Grantees Meeting in Bethesda, MD, July, 1994, sponsored by MCHB. Instruments previously developed to analyze the 1992 CISS initiative were modified to analyze the 1993 projects. The review was conducted between May and October, 1994.

Results

Data from the analysis are presented under three major headings: background variables, program variables, and plans for outcome evaluation.

Background Variables

Data were reviewed under each of the following categories of background variables: child, maternal, family, and community. The specific variables included child and maternal health and lifestyle characteristics, family socioeconomic status, racial/ethnic composition, community geographic location and description, and catchment area. Each of these variables is discussed in the report that follows this summary.

The nine CISS projects are located in the following states: Connecticut, Florida, Minnesota, Mississippi, Nebraska (2), Oregon, Washington, and Wisconsin. These

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locations are representative of the regional variation of the United States. The programs vary widely on the parameter of racial/ethnic composition, reflecting the diverse population of the United States.

Program Variables

The following program characteristics were examined: (1) level of service integration; (2) identification of services offered; (3) identification of specific service strategies; (4) identification of principles for human service care; and (5) personnel.

1) Level of Service Integration

Each project was reviewed to identify the level at which integration of services was proposed. For this report, we have looked for integration at the client level and at the agency or system level. In client-level integration, the client is assisted directly in service integration or coordination. In agency-level integration, the focus is on administrative procedures.

The most common method of client-level integration involved the use of a case manager who worked directly with each client to coordinate access to services for all of the client's health needs. The case managers were stationed at central services sites and/or mobilized as home visitors and family health advocates within the residences of the target population.

Agency- or system-level coordination efforts were more variable, ranging from modification of organizational infrastructure at the state level to regular meetings of program directors representing the service agencies of the community.

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2) Services Offered

The written documents of each CISS project were reviewed to determine what type of services were offered. Program services were aimed at children, mothers, the community, and the system as a whole. The focus of these services was quite diverse across the projects and addressed a number of issues, including child and maternal health (e.g., primary/pediatric care), child development, parent lifestyle behaviors (e.g., drug use), supportive services for mothers and families (e.g., transportation), and services to meet community and system needs (e.g., outreach).

3) Specific Service Strategies

The 1992 CISS guidance encouraged the use of at least one of six different strategies in developing community integrated service systems. Of these six, only two were used in the 1993 projects -- home visiting (six projects) and one-stop shopping (seven projects).

4) Principles of Care

The written documents of each CISS project were reviewed to determine the extent to which they adhered to the ten principles of care defined in the 1993 Guidance (family-centered, community-based, coordinated, culturally-competent, comprehensive, collaborative, universal, accessible, developmentally appropriate, and accountable) in their design, initial implementation, and evaluation plans. Some of these principles were clearly identified by the projects; others were less apparent in the written documents.

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5) Personnel: Staff Hiring, Training, and Supervision

Staff Hiring. Six of the nine CISS projects created a new home visiting program or expanded an existing one, with most projects hiring additional staff to implement this service strategy. Four of these projects reported establishing minimum educational requirements for their new staff, which clustered into paraprofessional (high school diploma/GED) and professional (bachelor's degree or higher) home visitor criteria.

Five of the nine projects also reported using additional hiring criteria beyond the educational requirement. Although these criteria varied widely across projects, most projects agreed on the requirement that the home visitors reside within the community.

Training. Only three projects that hired additional home visiting staff reported on the proposed training curriculum in their grant application. The content of training described by these projects can be grouped into three major areas: a) agency policy and documentation procedures, b) maternal and child health related knowledge, and c) interpersonal skill development.

Supervision. Information regarding the models or methods of supervision of home visitors was not elaborated on in the written documents.

Plans for Outcome Evaluation

All 1993 CISS projects identified a number of outcomes that they planned to measure to determine the effectiveness of their programs. These outcomes are divided into child, maternal, and community characteristics. A variety of methods were used to collect outcome data in each of these areas, including review of medical records, birth

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certificates, vital statistics, interviews with clients and project personnel, and daily logs or notes kept by project personnel.

Child

Within this area, eight of the nine projects indicated that at least one child measure would be used to document the effects of their efforts. All projects mentioned data collection on child health (e.g., immunizations, pediatric care). Fewer projects reported that they would collect outcome data on developmental issues (cognitive, social, emotional factors) or other family issues (e.g., child abuse).

Maternal

Within this area, there were no consistent patterns across projects regarding maternal outcome data to be collected. Generally, maternal health, lifestyle behaviors (e.g., smoking, teen pregnancy), and support services (e.g., coping skills, transportation, mental health) were targeted for data collection by at least one project.

Community

Within this area, almost all of the projects (eight of nine) indicated that they would collect outcome data on outreach activities carried out in the community. The specific information to be collected and the methods to be used varied across projects.

Summary and Recommendations

A review of the written documents shows that the 1993 projects have been responsive to CISS guidelines in considering principles of care in their planning and initial implementation efforts. Strategies that have been used by projects include either home visiting, one-stop shopping, or a combination of these two. The specific selection of

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procedures and strategies appears to be responsive to the needs of the target populations and to the available community resources. This expansion of the CISS initiative is continuing evidence of MCHB's support of integrated services for infants, children, and their families.

There are needs, however, that can be identified for almost all projects, especially in the areas of personnel hiring, training, and supervision, technical assistance in addressing barriers to the implementation of integrated services, and technical assistance and extra resources to support the timely evaluation of program implementation procedures and outcomes.

Based on the review of the 1993 CISS projects, the following eight recommendations are made. These recommendations are elaborated in the report that follows.

1. Additional interactions among the projects should be facilitated.
2. Additional interactions of the CISS projects with MCHB are recommended.
3. Technical assistance for general project development and implementation is recommended.
4. Specific technical assistance for staff training, including information on materials and procedures, is recommended.
5. Technical assistance in developing and implementing supervisory procedures is recommended.
6. General assistance with implementing principles of care is recommended.
7. Specific assistance in the development and implementation of evaluation

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procedures is recommended. The need for additional evaluation resources should be assessed.

8. Additional analyses of the CISS projects are recommended to obtain data on broader questions of service integration as well as more specific information on program implementation.

The 1993 CISS Projects:

A Report of the Initial Plans and Implementation Efforts

I. Introduction

Building on a long history of support for the development of intervention programs for infants and their mothers, the Maternal and Child Health Bureau (MCHB) funded nine community integrated service system (CISS) projects in 1993 to address concerns with infant mortality and to improve the health of all women and children in the United States. These projects emphasized the creation of service systems that incorporated ten specific principles of care: family-centered, community-based, coordinated, culturally-competent, comprehensive, collaborative, universal, accessible, developmentally appropriate, and accountable.

The focus of these 1993 CISS projects reflected a broadening in scope from the Bureau's first funding cycle for this initiative in 1992. The 1992 CISS initiative emphasized the utilization of six specific service strategies, including home visiting and one-stop shopping, to create a system of services located within the community especially for those pregnant women at risk for infant mortality. The Bureau broadened the scope of the 1993 CISS initiative, first by extending the population to include all pregnant women and children, and second, by identifying a specific set of principles of human service care that were to be incorporated by each funded project. The specific purpose of the 1993 CISS initiative was stated as follows: "In order to respond to the need for coordinated services, MCHB has established the development of community-based service systems as a top priority. The systems are intended to: promote physical, psychological, and social

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well being for all pregnant women and children, adolescents and their families; provide individualized attention to their special health care needs; and link health care and services with other services and programs including but not limited to early intervention, educational, vocational, and mental health services" (p. 1).

The CISS initiatives represent an effort on the part of the Bureau to build upon a tradition of concern in this country with the health and well-being of children and mothers (Shonkoff & Meisels, 1990; Wasik, Roberts, & Lam, 1994) and include an interest in identifying both medical and environmental procedures to be used in prevention and intervention efforts. Historically, different positions have been taken on ways to improve infant health, beginning with the emphasis upon post-natal care that characterized conditions during the last half of the nineteenth century and into the first part of this century. Maternal health did not become linked with infant mortality until the early 1900s (Merkel, 1990). Many believe that the higher United States infant mortality rates are attributable to the fact that the U.S. has focused more on improving medical conditions than social conditions, and that the country has not provided adequate financial and social support to families with pregnant women and infants (Wagner, 1988; Merkel, 1990). The CISS initiatives constitutes a major step forward in bringing together a number of important variables to address the health and well-being of infants, children, and women.

The Bureau's interest in providing services in the community that are integrated, coordinated, and family-centered is consistent with a shift in philosophy across all areas of human service care including health, education, and social services to provide services that are more family-focused rather than child-centered and that are preventive in nature

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(Brewer, McPherson, Magrab, & Hutchins, 1989; Hutchins & McPherson, 1991; Koop, 1987; McGonigal, Kaufman, & Johnson, 1991; Roberts, Barclay-McLaughlin, & Cleveland, 1990; Wasik et al., 1994). In 1990, Huxley, based on his review of community mental health services in both the United Kingdom and in the United States, identified a set of goals, principles, and ideals from the community mental health literature. He listed the following concepts as being common to community mental health providers on both sides of the Atlantic: comprehensive, coordinated, accessible, acceptable, efficient, effective, accountable, and evaluated. The principles articulated in the 1993 CISS guidelines as important in community services are generally congruent with the conclusions reached by Huxley.

The importance of the community in coordinating existing services has been noted previously by Hazel, Barber, Roberts, Behr, Helmstetter, and Guess (1988), who wrote that: "...communities still need to coordinate existing services and advocate for new, needed services. Regardless of federal and state guidelines or mandates, the community is ultimately responsible for pulling together the various aspects of the systems...in such a way as to benefit ***families***" (p. 53). To mobilize and coordinate community resources, these authors recommended the development of a Community Approach to an Integrated Service System committee, referred to as a CAISS committee. They described the responsibility of the CAISS committee as designing and implementing an integrated, comprehensive service delivery system that would enable families to have most of their needs met within their own community. The philosophy and assumptions underlying the

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work of these authors is very similar to the philosophy and assumptions of the CISS initiative of the Maternal and Child Health Bureau.

In spite of the strong commitment to provide services that are integrated and community-based, only a few efforts have been designed to evaluate such services. These efforts include (a) ***Services integration: A twenty-year retrospective*** (Kusserow, 1991b); ***Services integration for families and children in crisis*** (Kusserow, 1991a); ***Integrating human services: Linking at-risk families with services more successful than system reform efforts*** (General Accounting Office, 1991); ***Coordination, collaboration, integration: Strategies for serving families more effectively, part one: The federal role*** (Ooms and Owen, 1992a); ***Coordination, collaboration, integration: Strategies for serving families more effectively, part two: State and local initiatives*** (Ooms and Owen, 1992b), and ***Getting it right: Evaluating integrated programs*** (Gardner, 1990).

The purpose of this report is to provide an analysis of the nine 1993 CISS projects and, based on this analysis, to make recommendations to MCHB. The report provides information on background variables, including participant and community characteristics; program variables/design, services, strategies, and principles of care; personnel; and evaluation plans, including the anticipated outcome variables. A summary of a subset of these data were presented at the Community Integrated Service Systems and Home Visiting Grantees Meeting, Bethesda, MD, July, 1994.

Analyzing integrated systems of care within communities is a complex endeavor. To be done in a comprehensive manner would require several levels of analysis and both quantitative and qualitative approaches.

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Looking within the system of care itself, for example, one could examine how services are being integrated across health, education, and social service agencies. One could take the community itself as the level of analysis and look intensively at community characteristics and organizations and how they facilitate or hinder service integration. Another way to examine community integrated services is to describe the characteristics of the service integration in relation to where in the system integration occurs. Many individuals have described integration as occurring at the client level or at the agency level.

To complete this report on the 1993 MCHB community integrated service systems, we focused primarily on program or project characteristics. In doing so, we obtained information on client and community characteristics as background variables and we included information on a number of program procedures and characteristics. Given that this analysis was conducted approximately 9 to 12 months after the programs were initiated, we did not have outcome data. Consequently, we have described program plans for evaluation efforts but have not examined outcome data.

The conceptual model used to review the programmatic aspects of the 1993 CISS projects is responsive to shifts in philosophy concerning services to children and their families (Wasik, et al., 1990; Wasik, 1993). As a result, it includes as background variables not only child characteristics, but family and social/environmental variables. The model also incorporates outcome variables that relate to the child, as well as to the family and the environment. Another important element of this model is its emphasis on program variables. Figure 1 illustrates the potential relationships between the background,

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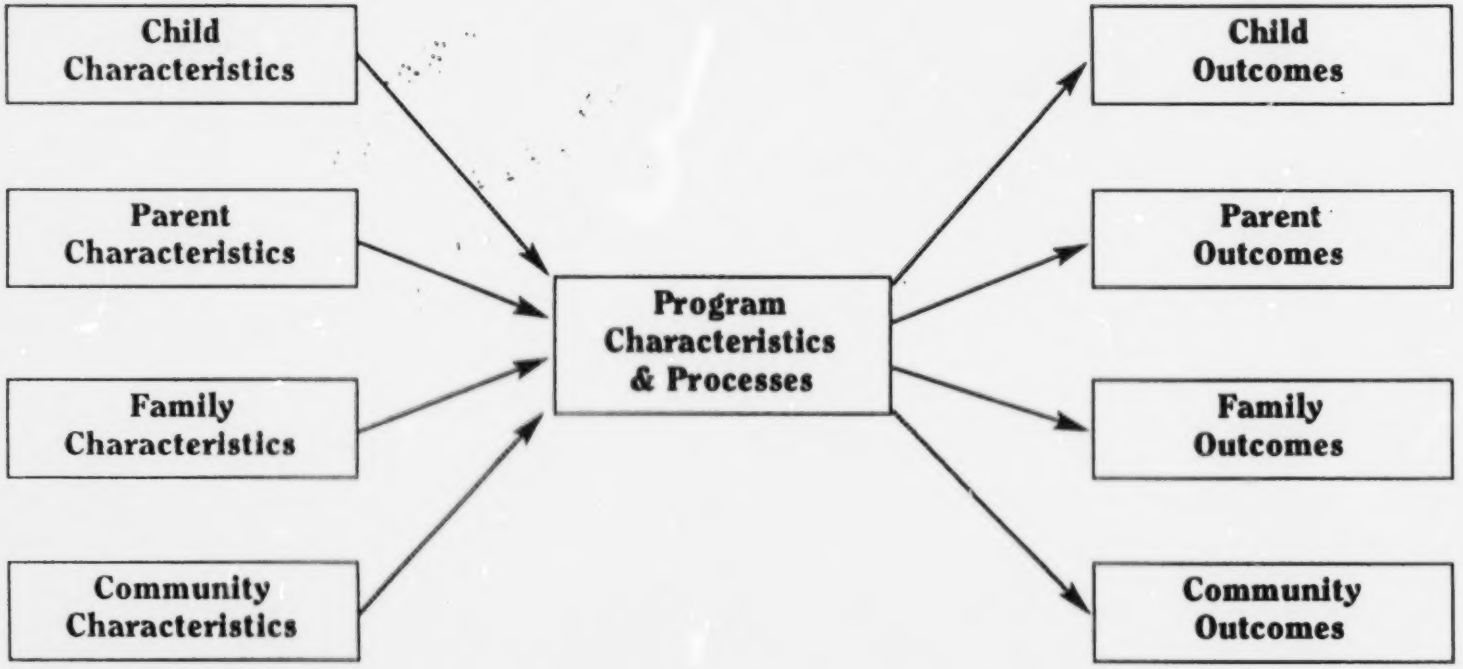
Conceptual Model Used in the Analysis and Evaluation of the CISS Programs



program, and outcome variables. The focus in this report is on describing programs as they were planned and implemented during the first year of the projects. The model is used as a framework for this review. It was outside the scope of this report to analyze relationships among variables suggested by this model.

Other models can be used for policy analysis studies on the CISS projects, for studying levels of service integration, or for studying ways services are integrated across health, education, and social services. Models of training and supervision and intervention philosophies can also be studied within the CISS projects.

II. Methods

The nine funded 1993 CISS projects were reviewed by a research team at the University of North Carolina at Chapel Hill.

Procedures

Two major review procedures were employed to obtain data for this analysis. First, all nine of the initial proposals were reviewed, followed by a review of the annual reports and continuation requests. The Initial Proposal Summary Form, developed for use in coding the 32 CISS projects funded in 1992, was expanded and used to record and summarize information obtained from the initial grant proposals submitted by the nine projects funded in 1993. The revised form was used to record both qualitative and quantitative data from each project, including demographic information, types of services offered, level of project integration, and information on the ten principles of care identified in the 1993 CISS guidelines for the proposals.

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The Annual Report Summary Form was developed to record information from the continuation grants submitted by each site. This summary form focused on programmatic changes in conceptualization and implementation as originally stated by the CISS projects, as well as barriers encountered during project development.

Completion of the Initial Proposal Summary Form and the Annual Report Summary Form for each of the nine projects required a thorough review of each submitted document and appendix, a task requiring approximately 6 to 8 hours per project. These two forms are presented as Appendixes A and B.

Secondary Analyses

Data were reduced further in secondary analyses through the creation of Summary Tables where information was recorded primarily in a yes/no format. The development of this set of 12 summary tables was based upon a review of the 1992 and the 1993 data in order to have a set of tables that was inclusive of all 41 projects. These summary tables are presented as Appendix C.

The secondary analyses permitted summarization of selected variables across the nine projects. Because a portion of the data in the proposals and continuation grants did not lend itself to this type of quantitative format, data from both the Proposal Summary Forms and the Annual Report Forms, as well as the 12 Summary Tables, were essential for a complete description of each project. (Versions of the three data summary forms used for the 1992 CISS projects can be found in Roberts & Wasik, 1994).

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III. Results

The descriptive data on the programs in this section are presented consistent with the variables identified in the conceptual model, including background variables, program variables, and plans for outcome variables.

A. Background Variables

A number of client and social/environmental characteristics were summarized in order to describe the background variables of these projects. These data are described below under the headings of child, maternal, family, and community.

Child

Background information on child characteristics was organized into three areas: birth, health, and developmental factors. The majority of the 1993 projects mentioned problems in the areas of birth and health. Low infant birth weight and infant mortality were reported by seven of the nine projects as characteristic of the infant population targeted for services. Child health problems reported by three or four of the projects as characteristic of the target populations include inadequate pediatric care, primary care, immunizations, and a high incidence of child abuse and/or neglect. None of the projects identified developmental problems in their description of the target populations.

Maternal

Background information on maternal characteristics was organized into three areas: general, health, and lifestyle behaviors. General maternal characteristics described as problems by at least three projects included a predominance of young, single mothers living on low income or at the poverty level. In the area of maternal health, seven out of the nine projects

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reported poor or nonexistent prenatal care to be characteristic of their target populations. In the lifestyle behavior area, seven of the nine projects mentioned teenage pregnancy as being characteristic of their target populations. Other problems identified by at least two projects were the high maternal use of drugs, including alcohol and nicotine. Generally, the 1993 projects did not identify common problems with family supportive services that were characteristic of their target populations; however, three projects reported that transportation was problematic for mothers in their target populations.

Family

Socioeconomic level. The socioeconomic status of families in each community was categorized as high, low, or mixed. The majority of projects reported that the families they serve are living on a low income or are at the poverty level.

Racial/Ethnic composition. The clients vary widely on the parameter of racial/ethnic composition, reflecting the diverse population of the United States. In only one project were the majority of families of European American background. All projects were asked to submit racial/ethnic information for both their targeted and served populations. These data, presented in Table 1, provide evidence that projects are serving minority families.

Family support. The reported problems with family support that were characteristic of the target populations varied widely across projects. Three of the projects identified transportation as problematic for targeted families. Additional family support problems described by individual projects included the need for general mental health

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Table 1. Racial/Ethnic Composition of 1993 Project Communities*

	CT	FL (G)	MN	MS	NE (Om)	NE (Ot)	OR	WA	WI
RACIAL/ETHNIC COMPOSITION									
Targeted:									
% European American	5	55	60	37	30.8		92	90.1	8.4
% African American	20	40	14	62	66			2.9	10.1
% Asian American	2		17		0.4			2.7	4.3
% Native American			2		1.3	100	1.5	3.2	0. 5
% Yapik Eskimo/Athabasian Indian									
% Other	73	5	7	1	1.5		6.5	1.1	1.1
Served:									
% European American	2	30	25	14	25		92	85	43.8
% African American	10	69	25	85	70			3.5	40.0
% Asian American	2		25		1			6	15
% Native American			10		1		0.5	6	0.2
% Yapik Eskimo/Athabasian Indian									
% Other	86	1	15	1	3		6.5	0.5	1

Note: Data obtained from project proposals (Appendix A). Eight of the nine projects provided detailed information on the percent of targeted and served populations.

counseling, child care, support groups, and social support, as well as addressing cultural barriers.

Community

The problems reported within the community were quite variable across projects. High incidences of crime, violence, and unemployment were identified by at least three of the projects as being characteristic of the communities in which the target populations reside. Other problems mentioned by at least two sites included a lack of housing, telephone service, insurance, awareness of available services, and a low high school graduation rate. Individual projects reported environmental problems that varied widely, including a harsh geographic climate, a lack of heat/electricity, high motor vehicle death rates, drug dealing, HIV, cultural barriers, and a lack of social support.

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Table 2

Geographic Descriptions of the 1993 CISS Project Communities

Description	Number of Project Sites
Inner City	3
Urban	3
Suburban	0
Rural	3
Multi-county	0
Statewide	0
Multi-state	0
National	0
International	0

Geographic location and description. The geographic locations of the nine CISS projects are representative of the regional variation of the United States. The nine projects are located in eight states (Connecticut, Florida, Minnesota, Mississippi, Nebraska (2), Oregon, Wisconsin, and Washington). Project locations were further characterized according to the following categories: inner city, urban, suburban, rural, multi-county, statewide, multi-state, national, and international. These data are presented in Table 2.

Catchment area population. The population sizes of the CISS communities are presented in Table 3. The majority of population sizes listed reflect those of the targeted population within the catchment area. Some information was provided by several of the projects regarding the numbers targeted for services and the numbers actually served. However, data specific to the client population frequently were not provided.

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Table 3

Catchment Area Population Sizes of 1993 CISS Project Communities

Catchment Area Population Size	Number of Projects (n=9)*
to 25,000	3
to 50,000	2
to 100,000	0
to 500,000	3
to 1,000,000	0
over 1,000,000	0

*Based on responses from eight projects.

B. Program Variables

1) Services Offered

The 1993 CISS projects offered services in the areas of child, maternal, and community, reflecting the comprehensive approach of most projects.

Child. A number of projects provided direct and referral services which included primary/pediatric care, WIC, immunizations, nutrition, disease prevention efforts, and well-baby/well-child care. A range of other health services were offered through links with other projects, including Healthy Start, dental, hearing, and/or vision screenings. Child development services were also provided, though usually as referrals for early intervention. A limited number of direct developmental services were provided, such as screening, assessment, and Head Start projects. One project provided health assessment specifically for an adolescent population.

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Maternal. Maternal health interventions were provided as a combination of direct, indirect, and referral services for primary care, nutrition, WIC, and pre-, peri-, and post-natal follow-up, as well as to help clients to deal with special conditions (e.g., AIDS). Some projects also offered lifestyle and social support interventions for substance and alcohol abuse, smoking, domestic violence, mental health conditions, social support, child care, transportation, parent education, parenting skills, support groups, and home assessment in an effort to more fully address their clients' needs.

Community. Many projects offered one or two services within this area. The most common method (eight out of nine projects) was direct outreach into the community. Outreach activities conducted by the projects included going into the homes, visiting child care drop-in centers and neighborhood centers, going to local support groups, mailings, and public service announcements. The ultimate goal of these activities ranged from dispensing general information about specific topics (e.g., parenting skills) and community resources and services to finding "cases" that needed comprehensive services provided by the projects. Other services offered by individual projects within the environment included public awareness projects, home and car safety information, and assistance with housing and public transportation.

Consistency/Change Over Time

Review of the continuation grant/first-year summary reports showed that none of the 1993 projects reported modification of their conceptualization of a community integrated service system over time. Rather, the projects' stated goals and objectives were consistent with those identified in their original CISS proposals.

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Barriers to Implementation

The most commonly reported barrier to implementation in the continuation grants was the hiring and training of personnel (four of nine projects). Other obstacles encountered during the first year of implementation included insufficient funding, governmental regulations and bureaucracy, and building construction delays. One project cited difficulties in linking with other agencies, that is, a direct service coordination problem, as hindering its first year of implementation.

2) Program Strategies

Six strategies were specified in the 1992 CISS guidance, and projects were encouraged to use these strategies in developing community integrated service systems (see Roberts & Wasik, 1994). Of these six strategies, only two -- home visiting and one-stop shopping -- were reported by the 1993 projects as part of their integrated service systems. Six projects reported using home visiting and seven reported using one-stop shopping.

3) Principles of Care

All of the written documents were reviewed to determine whether projects incorporated into their design the principles of family-centered, community-based, coordinated, universal, comprehensive, collaborative, culturally-competent, developmentally-oriented, accessible, and accountable care. Each of these principles of care are described below with examples of how projects proposed to address them in their service systems. (See Appendix D for definitions presented in the 1993 CISS guidelines.)

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Family-Centered Care

Family-centered services, one of the most widely advocated principles of care (Wasik, et al., 1994), place considerable importance on input and feedback from the family and responsiveness to the specific needs of the family in terms of planning and delivery of services. A family-centered system of services is seen as recognizing and building upon the strengths of the individual and the family, respecting the diversity across families, and facilitating collaboration between parents and professionals. Though two of the 1993 projects specifically stated a philosophy emphasizing the pivotal role of the parents and family in maternal and child well being, family-centeredness was the most strongly represented principle of care in design. Seven characteristics of family-centered care were mentioned by over half of the 1993 projects, and included the following: parent participation in program design/implementation, parent participation in program evaluation, child served within the context of the family, services focused on family strengths/resources, services coordinated for each individual family, services flexible and responsive to family needs, and communication mechanisms present between professionals and parents.

Community-Based Care

This principle refers to services developed and implemented within the community. The system looks to the community to identify needs and utilizes the resources within the community to address those needs. State agencies often play a major role in facilitating community efforts. The principle of community-based care was strongly reflected in the 1993 projects, with six characteristics being recognized by over half the projects. These

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included the creation of services that are flexible, responsive to community needs, serve the family within the community context, are delivered at the local level, involve local providers of services and public officials or leaders in programming, and link the community with other service levels.

Coordination of Services

The principle of coordination of services is reflected by an array of services coordinated to assure timeliness, appropriateness, continuity, and completeness of care. Coordination can occur at the client, agency, or system level; it can also occur vertically across services from local to state or national levels. A variety of procedures utilized by different projects represent examples of coordinated care, including case management, service coordination, a service coordinator who filled multiple roles in the system, and services that were flexible and responsive to family needs. System-level activities of coordinated care described in project reports included a monitoring system that tracked client needs in a systematic manner, and program mechanisms for family feedback on service integration efforts.

Universal Care

Universal care is defined by a focus on all members of the community or on a specific subgroup (i.e., pregnant women, children, adolescents, families), whether served by private providers or public programs. Universal care was the principle of care least evidenced by the 1993 projects. Only three of the nine projects appear to provide community-wide universal services, with most focusing on more targeted populations within the catchment area.

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Comprehensive Care

Comprehensive service systems encompass a range of levels of health care across a variety of areas. Services can include primary, secondary, and tertiary levels of health care that extend across areas such as physical, mental, and oral hygiene, with both a preventive and on-going care focus. Services can address the many specific needs of clients and can go beyond the realm of direct health care to incorporate vocational, social, educational and recreational services. Projects appeared to be highly responsive to the need for comprehensive care, with five characteristics of this principle represented in over half of the program descriptions. Specifically, five or more projects included in their design primary and physical health care, social services, parent/patient guidance and education, and services that addressed specific family needs such as substance use/abuse counseling, vocational and recreational services, and early intervention programs.

Collaborative Care

The implementation of collaborative care can be defined as occurring at the state, community, or family level. At the state level, collaboration efforts can occur among various state agencies through such efforts as organizational infrastructure (e.g., consortium arrangements). Community level collaboration is reflected in efforts that link private and public partnership resources, while family level efforts call for family participation in the development and implementation of service systems. Projects reported collaboration at each of these three levels, with five or more projects describing collaboration among state programs serving the community and promoting care at this

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level, collaboration among public and private resources, collaboration within the community, and family participation in program development.

Culturally-Competent Care

Culturally-competent care can be defined as services that are knowledgeable of the cultural diversity of their clients and that respond in a culturally sensitive manner to the varied needs of different cultural groups. Cultural awareness and competence can be present at policy, administrative, and practice levels, and can be demonstrated through acknowledgment of and respect for culture-related beliefs, values, interpersonal styles, attitudes, and behaviors. For example, multicultural staff and materials can be utilized to reduce cultural barriers to services. Five or more of the 1993 projects identified four or more characteristics of culturally-competent care, including the acknowledgment of culturally different groups in the targeted area, a strong base of cultural knowledge, minority participation in program design and implementation, and the provision of services that are flexible and responsive to different client needs.

Developmentally-Oriented Care

The system that is created to be developmentally-oriented considers the varying needs of children, adolescents, and families at different periods across the life span. For example, projects may provide pregnancy and health information for expectant parents, child development education for new parents, or focus on issues unique to special needs children. Projects indicated a responsiveness to developmentally-oriented care, with five projects describing services aimed at being flexible and responsive to the varied needs of

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children, adolescents, and families at different developmental stages, though projects focused most on promoting understanding of the development of infants and children.

Accessible Care

To provide accessible care, projects need to address potential barriers to services in their communities. Services can be conveniently located, and brought to the client, if necessary. Flexible hours and fees can be used wherever possible in order to bring services within the reach of all who need them. Project descriptions reflected notable responsiveness to accessibility needs of their clients. Three main characteristics of accessible care mentioned by over half of the projects included conveniently located and administered services, flexible hours, and affordable fees. More specifically, projects established joint visits for mothers and infants to avoid unnecessary multiple trips, increased Medicaid eligibility for clients in the target area, and offered services in homes to ensure their delivery.

Accountable Care

Accountable care focuses on the inclusion of procedures to obtain feedback about performance and utilization of services by clients in order to ensure best professional practices in service delivery. The most commonly identified strategy (seven of nine projects) for ensuring service accountability was the existence of feedback mechanisms between clients and professionals, including evaluation of program implementation within the system. Examples of accountable care procedures included group meetings and individual interviews with clients about the services they were receiving, as well as on-going documentation review of processes within the system.

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In summary, given the increasing focus within MCHB on family-centered, community-based, coordinated, culturally-competent care, and the emphasis on these principles in the CISS guidance, it was anticipated that projects would recognize the need to incorporate these principles of care in their initial proposals. Some of the principles, especially family-centeredness, were well articulated in the project proposals. Others, however, were less clearly identified. Culturally-competent program characteristics, such as training in cultural issues and the inclusion of minorities in planning and evaluation, were not mentioned very frequently by projects, despite their primary focus on culturally-distinct populations.

4) Service Integration

To elucidate the models of service delivery used by the nine projects, integration efforts were categorized as providing services at either the client level or the systems level; the type of integration at each level was also identified.

The most common method of client-level integration, utilized by eight of the nine projects, involved the employment of a case manager who worked directly with a client to coordinate access to services for all of that client's health needs. The case managers were stationed at central services sites and/or mobilized as home visitors and family health advocates within the residences of the target population.

Systems-level coordination efforts were more variable, ranging from increasing technological efficiency (through the establishment of computerized registries for access to client data) to regular meetings of directors representing the comprehensive service agencies of the community.

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5) Personnel

Staffing Issues

Staff hiring. Six of the nine CISS projects created a new home-visiting project or expanded an existing one. In most cases, additional staff were hired in order to implement the new effort. In this section, the criteria used by five of the nine projects in hiring new staff are discussed.

Four of the nine projects reported establishing minimum educational requirements for hiring new staff in home-visiting projects. These data are presented in Table 4. Minimum educational requirements clustered into two types. Some of the projects hired home visitors at the paraprofessional level represented by the high school/GED or partial college minimal educational requirement. Other projects hired home visitors with a bachelor's degree or higher. The bachelor's degree does not ensure professional status with respect to the home visitors themselves. That is, projects may require a bachelor's degree, but not necessarily in a related field such as social work or nursing. The minimum educational requirements for staff reported here for the 1993 CISS projects are consistent with data in the national survey of home-visiting programs (Wasik & Roberts, 1994). Both the CISS data and the survey data demonstrate that projects are staffed by professional and paraprofessional (or lay) home visitors across a range of educational backgrounds.

Five of the nine projects reported additional hiring criteria beyond minimum educational requirements, with a variety of skills mentioned as being important. It is

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Table 4

New Staff: Minimum Educational Requirements (n = 9)*

Educational Requirement	Number
High School	0
High School GED	3
Partial College	0
CDA	0
AA	1
BA or BS	1
Graduate Student	0
RN	1
MA/MPH	0
PNP	0
Volunteers	0
Literate	0

*Based on responses from four projects.

noteworthy that several of the projects were particularly interested in hiring individuals who resided in the local community. This finding suggested a programmatic concern that home visitors should be very knowledgeable about the community, its values and lifestyles. Other characteristics mentioned by one or two of the five projects included being a parent of a child with special needs, good communication skills, prior experience, warm personal qualities, cultural sensitivity, ability to work on a team, knowledge in areas such as maternal/child health, owning an automobile, and living alcohol/drug free.

Staffing models. Given the limited data provided by projects regarding the staffing of home visitors, definitive statements cannot be made about staffing models. Data regarding the educational requirements of home visitors, however, suggest that three staffing models similar to those identified by the 1992 projects, as well as other home

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visiting programs, may be utilized by the 1993 CISS projects. Staffing models included using professional home visitors only, using paraprofessional home visitors only, or using a combination of professionals and paraprofessionals in a partnership arrangement.

Training Issues

Although training new staff appeared to be a high priority and very time consuming during the first year of operation for most projects, only three projects reported on training issues in their grant application plans. (Documentation of training gathered on the 1992 projects during phone interviews with project directors after one year of operation provided important information on training. Interviews with the 1993 CISS project directors would be expected to yield additional information on training.)

Content of training. Three of the projects that hired additional home visiting staff reported on the proposed training curriculum in their grant application. The content of training described by these projects reflected a wide range of topics in three major areas: a) agency policy and documentation procedures, b) maternal and child health-related knowledge, and c) interpersonal skills development. Within these three areas, training included information on procedures, documentation, evaluation, and agency policy (agency policy and documentation); human growth and development, family systems development, first aid and home safety, pregnancy, childbirth, and nutrition (maternal and child health knowledge); and communication skills with families and other professionals and outreach skills (interpersonal skills development).

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Supervision

While a few projects identified the individual responsible for supervision of home visitors (e.g., public health nurses, project directors), none of the projects provided information regarding the specific models or methods of supervision of home visitors. Such information could be obtained through follow-up interviews.

C. Plans for Outcome Evaluation

The 1993 CISS project evaluation plans, as documented in the proposals, were reviewed for all projects. In this section, the evaluation plans are described, followed by documentation of the domains typically suggested for evaluation across all projects.

Evaluation Plans

In most cases, the evaluation component of the 1993 CISS proposals was less comprehensive than other areas within the proposals. While most of the projects did identify the issues within child, maternal, and community areas that would be targeted for outcome data collection, very few provided information about how this information would be collected. For example, many projects planned to track the numbers of people being served, or the number of services provided, but they did not specify how this would be done or how it would answer questions regarding the effectiveness of their projects. Two projects did report (in very general terms) using goal attainment or quasi-experimental designs to collect and analyze the outcome data. Four of the projects identified evaluation efforts not only for outcome data, but for process data as well. These projects proposed to examine ongoing program efforts to modify project strategies as needed in order to produce the most benefit to clients.

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Although all of the projects indicated that they would be collecting data on child, maternal, and community areas, what specific variables they would examine and by what methods varied across projects. Generally, a variety of methods were proposed to collect outcome data in each of these areas, including review of medical records, birth certificates and vital statistics, interviews with clients and project personnel, and maintenance of daily logs or notes recorded by project personnel.

Documentation of Child, Maternal, and Community Variables

All of the projects were reviewed with respect to whether they mentioned the child, maternal/family, community, or service system domains with respect to evaluation.

Child Domain

In their initial proposals, eight projects mentioned at least one child measure that would be used to document effects. These child measures were not necessarily standardized measures, but were proposed as a measure of child outcome. Less than half of the projects mentioned that data on infant mortality and/or low birth weight would be collected within their target communities.

Almost all projects mentioned collecting data on the health care of children, including whether or not children were being immunized, or receiving pediatric care and well-child care as part of their systems. Few mentioned that they would collect specific measures of children's developmental progress. Only one proposal mentioned the collection of data on the incidence of child abuse and neglect among target children within its evaluation plan.

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Maternal/Family Domain

At least one maternal outcome was mentioned in the evaluation plans of five projects. The most commonly identified of these was whether or not mothers used prenatal care. Other outcome data collected varied widely and included such variables as primary care utilization, WIC, breastfeeding, and family planning. Outcomes relating to lifestyle behaviors and supportive services to families also were variable across projects. Issues targeted for measurement in the area of lifestyle behaviors included smoking, substance abuse/alcohol, domestic violence, and teenage pregnancy. Family support services to be evaluated included mental health, daily living/coping skills, childcare, transportation, parent education, parenting skills, child safety, and social service use.

Community Domain

Within this area, the majority of the projects (eight of nine) indicated that they would collect outcome data on outreach activities carried out in the community. The specific information to be collected and the methods to be employed varied across project sites. For example, one project is collecting data on the number of outreach activities conducted, the number of clients who are exposed to outreach activities, and the number of clients who use services as a result of the outreach activities, and will use all of these data to document the effectiveness of providing accessible, coordinated care.

Systems Services Domain

At least one service system variable was mentioned for evaluation by eight of the projects in their initial proposals, including referral/linkage to clients, provider follow-up, case management, interagency communication, accessibility of services, and provider-to-

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client ratio. Relatively little consistency was found across projects on the types of measures that were to be collected in this domain.

IV. Summary

A review of the written documents shows that the 1993 projects have been responsive to CISS guidelines in considering principles of care in their planning and implementation efforts. Most also included either home visiting, one-stop shopping, or both in their plans. The specific selection of procedures and strategies appears to be responsive to the needs of the target populations and to the available community resources. This expansion of the CISS initiative is continuing evidence of MCHB's support of integrated services for infants, children, and their families.

There are needs, however, that can be identified for almost all projects, especially in the areas of personnel hiring, training, and supervision, technical assistance for addressing barriers to the implementation of integrated services, and technical assistance and extra resources to support the timely evaluation of program implementation procedures and outcomes.

The following summary statements are the result of a review of the nine 1993 CISS proposals and incorporates feedback received at the 1993 Conference.

Background Variables

The first set of summary statements relate to background variables. Most projects identified specific infant or child characteristics, such as low birth weight, infant mortality, and inadequate pediatric care, as representative of their target populations. The dominant maternal characteristics mentioned were poor or nonexistent prenatal care, and teenage

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pregnancy. The projects reported serving individuals representing a wide range of racial/ethnic backgrounds; however, the majority have directed their services toward minority populations. The provision of universal services was not a major goal of these projects, although some have offered services to all individuals within a particular category of need (i.e., pregnant teenagers). Most clients were identified as low income. Community issues reported by projects include concerns with crime, violence, and unemployment.

Program Variables

The second summary area concerns program variables. In terms of services offered, projects described a range of direct and referral services, including primary/pediatric care, WIC, immunizations, nutrition, disease prevention, and well-child/baby care. Maternal services included a combination of direct, indirect, and referral services for primary care, nutrition, and pre-, peri-, and post-natal follow up. Some projects provided services that encourage healthy lifestyle changes. In terms of specific intervention strategies, six projects reported using home visiting and seven reported using one-stop shopping. Staffing and training patterns differed across projects, as did the required hiring credentials.

Many projects reported difficulties in implementing their programs, with hiring and training of personnel identified as problematic by four of the nine projects. Other obstacles included insufficient funding, governmental regulations, and building construction delays.

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The projects were attentive to the ten principles of care but there were differences across projects in terms of the amount of attention devoted to these principles. The principle that appeared to receive the most attention was that of family-centered care. All projects discussed issues related to building upon family strengths, respecting the diversity of families, and facilitating collaboration between clients and professionals.

Outcome Variables

The third summary area relates to outcome variables. Outcome variables are assessed in order to draw conclusions about program procedures and program effectiveness. Almost all projects reported their intent to evaluate one or more outcomes in the areas of child, maternal/family, community and system services. Almost all planned to collect data on the health care of children, including information on immunizations, pediatric care, and well-child care. The use of prenatal care was the most commonly identified maternal outcome to be evaluated. Family support data to be collected ranged from mental health counseling and coping skills to child care and transportation. The collection of data on outreach activities was the most commonly identified outcome to be assessed in the community domain. System service outcomes varied widely from linkage/referral of clients to interagency communication.

Overall, these nine projects have been responsive to the MCHB 1993 CISS guidance calling for the incorporation of principles of care into their planning and intervention procedures. However, an unevenness appears both within and across projects in the extent to which they have articulated ways to integrate these principles into planning and practice. Projects appear to be interested and committed to these principles on a

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philosophical level, but few projects have the resources to address all ten principles, or to conduct comprehensive process and outcome evaluations, even though projects appear to be very committed to doing so.

It is important to note that very few instruments are available for evaluation purposes. One instrument being developed for potential use with intervention programs is the Principles of Human Service Care Rating Scale. A draft version is presented in Appendix E.

V. Recommendations

Based on this review of the 1993 CISS projects, the following recommendations are made:

1. Additional interactions among the projects should be facilitated.

Projects have had to overcome a variety of obstacles in implementing their strategies. Providing opportunities for projects to share this information in a timely manner allows them to benefit from the experience of other projects. Additional interactions among projects (e.g., yearly meetings and teleconferencing) should be supported.

2. Additional interactions of the CISS projects and MCHB are recommended.

Ensuring opportunities for frequent communication makes it possible for MCHB to provide assistance in a timely manner and gain information that can be useful in anticipating needs of other projects. The 1993 conference was received very positively by the project staff. It is recommended that a national conference be held annually.

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3. **Technical assistance for general project development and implementation is recommended.**

There are a number of issues related to the development and implementation of any community-based project. Providing information on these topics across projects will ensure that projects have access to a common information base and resources in the implementation of their procedures.

4. **Specific technical assistance for staff training, including information on materials and procedures, is recommended.**

All projects are involved in providing in-service training to their staff. Some have developed their own materials, while others are utilizing materials developed by other programs. Providing information and resources in this area would ensure that projects are able to reach their own objectives.

5. **Technical assistance in developing and implementing supervisory procedures is recommended.**

During the conference, many projects expressed an interest in learning more about supervisory procedures, especially for home visitors. Providing information and resources in this area should help projects support staff and ensure the accomplishment of their goals.

6. **General assistance with implementing principles of care is recommended.**

Projects differed considerably in the implementation of the principles of care. Technical assistance in this area might best be provided to each project individually because of the differences in specific project goals, clients, and procedures. For some

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principles (e.g., coordinated care), there are a number of written materials which provide valuable information in anticipating difficulties and in implementing effective solutions.

7. **Specific assistance in the development and implementation of evaluation procedures is recommended. The need for additional evaluation resources should be assessed.**

Project staff have expressed a strong desire to receive more information about the evaluation process and to have more resources with which to conduct their evaluations. Information received from these project evaluations can be very valuable to MCHB, not only in the CISS initiative, but in other funding efforts.

8. **Additional analyses of the CISS projects are recommended to obtain data on broader questions of service integration as well as more specific information on program implementation.**

Future evaluations could be expanded in several ways through both quantitative and qualitative data collection procedures and through more than one research methodology. More detailed information on program implementation could be obtained, including information on staff roles and responsibilities and client experiences. Evaluations can be enhanced by obtaining information from multiple sources. Longitudinal data could be obtained across the duration of these projects, particularly information on the ten principles of care emphasized in the guidelines. Policy analysis studies can be conducted. Service integration can be reviewed to determine any coordinated efforts across health, education, and social services. The projects are also

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potentially valuable sources of information for studying staffing, training, and supervision patterns and barriers to program implementation.

Because so few studies have been conducted on community integrated service systems, it would be desirable to pursue additional analyses of the CISS initiatives. They are a rich source of information that can be used to inform future policy and practice.

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